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Schmieding /ILC Solutions Forum on Elder Caregiving

June 2, 2005 ♦ 9 am -12 noon

Schmieding Conference on Elder Homecare

June 2, 2005 ♦ 12 noon - 4 pm

REPORT OF FINDINGS

KATHLEEN THIMSEN

ESTABLISHING STANDARDS FOR IN-HOME DIRECT CARE WORKERS

SOLUTIONS FOR KEEPING ELDERS AT HOME FOR LIFE

TESTIMONY OF KATHLEEN THIMSEN RN ET MSN FNS TO THE POLICY COMMITTEE OF THE WHITE HOUSE CONFERENCE ON AGING

Kathleen Thimsen is an RN with a Masters of Family Systems Nursing and twenty-eight years of clinical experience.

Ms Thimsen has practiced in acute care and academic medical centers, long term care and private practice settings. Her home care and hospice experiences span from 1983 to the present time.

In the early 1990's Kathleen developed a software program which provided trend analysis and reporting on the triad of outcomes: clinical, quality and economic data related to clinical management of catastrophic patient populations. This program was acquired by an international corporation to create the infrastructure of a global healthcare expenditure reporting program.

Kathleen has published thirty-one articles, authored chapters for textbooks, poster presentations, and oral abstracts. She has also co-authored many publications and was one of the steering committee members from the International Association of Enterostomal Therapy (IAET) that provided utilization parameter recommendations to CMS for ostomy and the surgical dressing policy # 2079. She was also one of the four authors for the OASIS Skin Integrity Interpretive Guidelines for Home Health that is endorsed by HCFA now CMS.

Her clinical practice interest is focused on the provision of quality health and medical care aimed at the unit of care model. The operating definition of "unit of care" for this presentation is the patient and caregiver(s). Caregiver(s) may include: a) family, b) paid family and/or c) paid care providers.

Kathleen believes that standards for home care should apply to all providers regardless of payer source. She believes this goal can most effectively be achieved by formulating standards of care, education, training competency testing and certification for caregivers at all levels.

SUMMARY OF FINDINGS

DS was a homebound, disabled adult with Multiple Sclerosis. Her father was her primary caregiver. He was 75 years old and was working 10 hours/day to pay for his daughter's care. He was paying a Personal Care Agency (PCA) \$120 a day for a caregiver to provide care. In addition to the PCA's services, the care was being augmented by an untrained neighbor who felt overwhelmed with "not wanting to hurt DS" and "not knowing what she exactly needed to have done or how to do it."

Our physician home care practice was asked by the father to see the patient because of his concern for her "multiple sores and weight loss." He reported that he had been unable to persuade the primary care doctor to see her at home and that it had been greater than 2 months since a registered nurse from the PCA had assessed DS's needs and condition.

During our initial home visit we determined that DS was not receiving appropriate care based on the following findings:

- Poor hygiene demonstrated by dirty hair, skin, fingernails, toenails and skin breakdown related to fecal incontinence
- Poor nutritional status: significant weight loss and the appearance of wasting
- Immobility and contractures
- Twenty-two infected and necrotic pressure ulcers
- Urinary tract infection and encrustations to urinary catheter
- Bowel impaction

These findings indicated that DS was paying for care and services from a PCA but clearly, was not receiving appropriate or necessary care.

DS's medical needs clearly met criteria for skilled care under Part A Home Care. She was not receiving those benefits as her father was not aware of her eligibility.

Had the PCA been required to a) evaluate her condition on a frequent (every two week basis), b) communicate pertinent findings to her physician and c) refer the case to a Medicare skilled home care agency, we believe that her condition would not have deteriorated to the severity of the findings.

This case emphasizes the need for establishing standards for in-home direct care workers that include education, training, and validation of competencies. This level of care giving should be subject to the same standards as those required by Medicare.

In accordance with the Patient Safety Initiatives within our health and medical care systems, having a critical mass of caregivers who are not properly trained and whose skills are not evaluated or validated, places our vulnerable population at risk for mistreatment and serious injury. Furthermore, paying for care with the expectation of a competent caregiver and actually receiving “sub- standard” care would be considered fraudulent under our Medicare system and standards.

Planning for the Future

The demand for caregivers will increase over the next 20 years. Driving the need are the following well-researched and published facts:

- Senior population explosion
- Limited public health resources to meet the needs of the growing segment of consumers
- Limited success in recruiting medical, nursing and ancillary healthcare providers
- Limited pool of family caregivers available to provide care
- Limited access to state funded programs due to state Medicaid budget cuts (Pear, 2003)
- Limited access to state funded programs due to federal regulation restrictions on the number of people who may be served under waiver programs. (Stucki & Mulvey)

Sorenson, Pinequart & Duberstein (2002) along with Rowe & Kahn (1998) documented family and patient education as being the cornerstone of decreasing expenditures, improving overall outcomes.

Health saving accounts, supported by the current administration, would allow consumer driven decisions about individual healthcare spending. Standardization and criteria for utilizing the savings account funds will need to be developed.

Direct care workers will be a growing segment of care providers as the resource and supply of healthcare workers is unable to meet the needs of the aging population. Published studies have identified that the medical, clinical and personal needs of the aging population receiving care have exceeded acuity levels previously seen and limited to the intensive care unit and have become common in the long term care and home care settings.

RECOMMENDATIONS

- Standardized education and training that meets an industry standard of comprehensive care procedure and performance of skills
- Required, on going, education to keep the caregivers knowledgebase on track with acquity and technologic advances that becomes available and standard in the home environment.
- Skills training, demonstration of competency and validation of care techniques and skills required to provide safe and appropriate care/services to the senior population.
- Safe-care environment provisions to minimize potential for abuse, assault, fraud, and negligence.
- On-going method for continuous monitoring of an individual's needs to insure appropriate direction and referral for appropriate care
- Certification (all levels)
- State registry linked to national caregiver credentialing databank. Purpose: credential depository and verification of background, consumer complaints, and criminal checks.
- Development of part b based benefit program that would provide coverage for direct caregivers meeting the requirements of a standardized program.
- Training requirements for familial caregivers receiving payment for rendering care
- Benefit programs to encourage recruitment and retention in caregiver roles and career paths

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